

## **DRAFT**

### **Blue Ribbon Commission on Child Protection** **Draft Interim Report Recommendations**

**December 13, 2013**

Of one thing we are certain: The children of Los Angeles County can and deserve to be safer than they are at present. Consequently, the Blue Ribbon Commission on Child Protection (Commission) will issue a complete set of recommendations in its Final Report due April 18, 2014, to the Board of Supervisors (Board).

We are aware that hundreds of child welfare-related recommendations have already been offered to the Board over the past eight years. A system within the County is lacking to manage vetting, implementation, and assessment of the volume of child protection recommendations.

We propose that following submission of our Final Report in April, one coordinating entity should work with the Board to ensure that all relevant departments are accountable for improved child safety. That entity should assist those departments in developing joint strategic plans, mechanisms for measurement, and combining resources to enhance the well-being of children. All recommendations should focus as a priority on child safety, and that entity should be directed to independently monitor implementation of recommendations approved by the Board as designed to improve child safety.

Prior to issuing our Final Report, the Commission already has agreed upon a few immediate steps the County can take to improve child safety. We are presenting these recommendations to the Board in our Interim Report so they can be implemented as soon as possible.

#### **Law Enforcement**

As required by State law, an independent, second set of eyes to those of the Department of Children and Family Services (DCFS) can be the difference between a safe child and one who is seriously injured or dies. There should be a consistent and swift response across law enforcement agencies to every allegation of child abuse. Further, all levels of law enforcement should receive mandatory and recurrent training on their respective responsibilities. Allegations originating from DCFS through the Electronic Suspected Child Abuse Reporting System (E-SCARS) should be treated with equal importance as calls made directly to a law enforcement agency from a resident or mandated reporter. E-SCARS is the County's innovative information sharing system available for use by DCFS, every law enforcement agency in the County, and County and City prosecutors.

#### **Recommendations:**

1. All Sheriff's deputies and law enforcement officers should cross-report every child abuse allegation to DCFS and document that cross-reporting in a written report.

2. E-SCARS should be utilized fully by all relevant agencies and receive the support that it needs to be well-maintained and enhanced.
3. The District Attorney should increase its oversight of the law enforcement response and sharing of information, including cross-reporting between DCFS and law enforcement agencies, to ensure that each agency carries out its mandated investigative response.
4. Law enforcement and DCFS staff should be co-located or otherwise collaborate closely to increase the speed of background checks for potential relative and other care providers. The current, sometimes lengthy, lag time for receipt of these reports delays placement decisions and has negative consequences for child safety.

### **Health Services**

For at risk children, complex medical or developmental issues may be symptoms of abuse or neglect. When those signs are missed or when they are not addressed, the risk of repeat abuse, serious injury or even death occurs. It is critical to ensure the best medical care for children at risk of becoming victims, or who already are victims, of abuse and neglect. Therefore, the medical HUBs should be fully implemented, as originally envisioned, to dramatically improve child safety.

#### **Recommendation:**

5. All children entering placement should be screened at a medical HUB. Children under age one whose cases are investigated by DCFS should be assessed at a medical HUB. Children placed in out-of-home care or served by DCFS in their homes should have ongoing health care provided by physicians at the medical HUBs.

Many young victims of abuse and neglect have complex medical and developmental challenges. The skills and expertise of Public Health Nurses should be used to improve and enhance DCFS's investigative processes. Their involvement would immediately and significantly improve decision-making. This approach has been utilized successfully in some communities around the country.

#### **Recommendation:**

6. A Public Health Nurse should be paired with a DCFS social worker in child abuse or neglect investigations of all children from birth to age one.

The use of the Department of Public Health's evidence-based home visiting provides many critical services to families at risk of abuse or neglect and should be expanded. This service has been proven to reduce the risk of subsequent abuse and neglect. Children reported to DCFS prior to age one are at the highest risk for later serious injury or fatality.

**Recommendation:**

7. The Department of Public Health’s evidence-based home visit service should be made available to all children under age one who are seen at a medical HUB.

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The following two categories of recommendations will be significantly expanded upon in the Commission’s Final Report, but, due to their fundamental importance, the Commission is highlighting its thinking at this early juncture.

**Children Age Five and Under**

In Los Angeles County, children under five years old account for approximately ninety percent of the fatalities due to abuse or neglect. Moreover, children under age one who are reported to DCFS, regardless of DCFS’s finding, are at the greatest risk for later fatality prior to age five, including both intentional and unintentional fatalities.

**Recommendation:**

8. The County can measurably and immediately improve child safety by requiring all departments to target their highest quality services, including prevention services and resources, toward children under the age of five, the most vulnerable population.

**Accountability**

The Board of Supervisors and County leadership should be able to answer the questions – confidently – of whether children are safer and whether the strategies being implemented are improving child safety. Process and outcome assessment is essential in the management of any system of care. In the case of DCFS, an example of an outcome measure would be the number of children who are abused after coming to the attention of any County department. A process measure might include how many families with children under age one receive evidence-based home visits from the Department of Public Health.

**Recommendations:**

9. The Board and County leadership must develop additional finely-tuned process and outcome measures, other than tragic child fatalities, to assess system performance.
10. All previous recommendations undergoing implementation by DCFS should be reviewed and prioritized to ensure that implementation will improve child safety and/or contribute to the effectiveness of DCFS’s mission.